Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:	MFDR Tracking #: M4-09-B558-01
MICHAEL MAIER, M.D 15200 S.W. FRWY. STE. 290 SUGARLAND, TX. 77478	
Respondent Name and Box #:	
LIBERTY INS. CORP. REP. BOX # 28	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: Position summary not submitted to MDR.

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $56.61 *
3. CMS 1500s
4. EOBs
5. Medical records

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: Position summary not submitted to MDR.

Principle Documentation:

1. Response to DWC 60
2. EOBs

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
4-14-08	G0289-RT 76000-RT	42,Z710,24,P303,Z346	1, 2, 3, & 4	$29.49 $0.00
Total Due:				$29.49

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.203, titled *Medical Fee Guideline for Professional Services* effective for professional medical services provided on or after March 1, 2008, set out the reimbursement guidelines.

* Requestor submitted a new Table of Disputed Services and that Table is used in this review. *

1. These services were denied by the Respondent with reason codes "42" (charges exceed our fee schedule or maximum allowable amount), "Z710" (the charge for this procedure exceeds the fee schedule allowance), "24" (charges are covered under a capitation agreement/managed care plan), "P303" (this service was reviewed in accordance with your contract), "Z346" (right side).
2. A review of the EOBs and of the Disputed Table identify that a total of $115.45 has been paid for code G0289 and a total of $107.44 has been paid for code 76000. In accordance with the Division's fee schedule, additional monies are owed for code G0289. The additional payment is recommended in accordance with Rule 134.203 (b) and (c) (1).
   - G0289: $66.32 divided by 38.087 x $83.24 =$144.94
   - $144.94 - $115.45 (paid) =$29.49 (owed for G0289)
   - 76000: $52.83 divided by 38.087 x $77.46 =$107.44
   - $107.44 - $107.44 (paid) =$0.00
3. A review of the EOB (s) identify that the 'paid column (s)' is equal to the 'PPO allowable column' and the 'review allowable column' signifying that there was no negotiated contract reduction made; therefore, the Division's payment recommendation is made in accordance with the MAR. (maximum allowable reimbursement)
4. Per review of Box 32 on the CMS-1500, zip code 77479 is located in Fort Bend County. The maximum reimbursement amount under Rule 134.203 (b) is determined by locality.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section 413.011(a-d), Section 413.031 and Section 413.0311
28 Texas Administrative Code, Rules 134.1, 134.203
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to additional reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $29.49 plus applicable accrued interest per Division Rule 134.130, due within 30 days of receipt of this Order.

ORDER:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.